



# Handbook for Providers of School Based/Linked Health Center Services

## Chapter S-200 Policy and Procedures School Based/Linked Health Centers

**Illinois Department of Healthcare and Family Services**

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# Chapter S-200

## School Based/Linked Health Centers

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## **Foreword**

### **Purpose**

This handbook has been prepared for the information and guidance of providers of School Based/Linked Health Center (SBLHC) services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

The [Handbook for Providers of School Based/Linked Health Centers](#) can be viewed on the Department's website. This handbook provides information regarding specific policies and procedures relating to SBLHC services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at [Provider Notices webpage](#).

Providers will be held responsible for compliance with all policy and procedures contained herein. Providers wishing to receive [e-mail notification](#) of new provider information posted by the Department may register on the website.

**Inquiries regarding billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.**

## Acronyms and Definitions

**Department of Healthcare and Family Services (HFS), or Department:** The Department of Healthcare and Family Services (HFS) or Department is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs, including All Kids, FamilyCare, Veterans Care, and Health Benefits for Workers with Disabilities (HBWD).

**Document Control Number (DCN):** A fifteen-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS.

CC	First 2 digits of the century claim was received
YY	Last 2 digits of year claim was received
DDD	Julian date claim was received
LL	Document Control Line Number (most commonly 15 for paper, 16 for paper with attachment, 17 for paper with override, 22 for electronic, 23 for electronic Medicare crossover)
SSSSSS	Sequential Number

**Fee-for-Service:** A payment methodology in which reimbursement is considered for each service provided

**HCPCS:** Healthcare Common Procedure Coding System.

**[HFS 2360 \(pdf\)](#):** The Department of Healthcare and Family Services Health Insurance Claim Form.

**National Drug Code (NDC):** A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The National Drug Code (NDC) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

**National Provider Identifier (NPI):** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

**Procedure Code:** The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

**Provider Enrollment Services (PES):** The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

**Recipient Identification Number (RIN):** The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

**Remittance Advice:** A document issued by the Department which reports the status of claims (invoices) and adjustments processed. This may also be referred to as a voucher.

## Chapter S-200

### School Based/Linked Health Centers

#### S-200 Basic Provisions

For consideration of payment by the Department for School Based/Linked Health Center services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs. This handbook is intended to be used in conjunction with the [Chapter 100](#) General Policies and Procedures Handbook, the [Handbook for Practitioners Rendering Medical Services](#), and the [Chapter HK-200 Handbook for Providers of Healthy Kids Services](#). The [Handbook for Practitioners Rendering Medical Services](#) includes guidelines and specific billing procedures applicable to providers of primary care services. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook apply to participants enrolled in traditional fee-for-service, [Accountable Care Entities \(ACEs\)](#) and [Care Coordination Entities \(CCEs\)](#) and do not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Providers submitting X12 electronic transactions must refer to [Chapter 300](#), Handbook for Electronic Processing. [Chapter 300](#) identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by the Illinois Department of Healthcare and Family Services.

## **S-201 Provider Enrollment**

School Based/Linked Health Centers (SBLHC) must be certified by the Illinois Department of Public Health (IDPH) and meet the standards established in [77 Ill. Adm. Code, Part 2200](#). IDPH will assign an initial certification date. Certification will be reviewed by IDPH every two years.

### **S-201.1 Enrollment Requirements**

To comply with the Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#), Illinois has implemented a new electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

To obtain more information and/or to enroll in IMPACT, providers are directed to the [IMPACT website](#).

**Enrollment approval is not transferable** - Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

### **S-201.2 Enrollment Approval**

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix S-200. The School Based/Linked Health Center will be enrolled as a Provider Type 56. If a School Based/Linked Health Center is eligible to enroll as a FQHC, RHC, or other provider type, contact Provider Enrollment Services (PES) for assistance.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. Inaccuracies are to be reported immediately via IMPACT.

### **S-201.3 Enrollment Denial**

When enrollment is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the applicant may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being

challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are set out in [89 Ill. Adm. Code 140.14](#). Department rules concerning the administrative hearing process are set out in [89 Ill. Adm. Code 104 Subpart C](#).

#### **S-201.4 Provider File Maintenance**

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

##### **Provider Responsibility**

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims. Any inaccuracies found are to be corrected and the Department notified immediately via IMPACT.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

If a provider does not submit a claim to the Department for 12 months, the provider number will go into a non-participating status. No Provider Information Sheet is generated to alert the provider that they have gone into a non-participating status. If a claim is submitted after the non-participating status is in effect, the claim will reject with a comment indicating Nonparticipating or Missing/Incomplete/Invalid Credentialing. Prior to resubmitting the claim for processing, the provider must contact the PES to change the non-participating status. PES can be reached by calling 877-782-5565 or by [e-mail](#).

##### **Department Responsibility**

When a change has been made to the provider file, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the "Pay To" address is different from the provider address.

## **S-202 School Based/Linked Health Center Reimbursement**

### **S-202.1 Charges**

Providers are to submit charges to the Department only after services have been rendered. Charges are to be the provider's usual and customary charges to the general public for the services provided. To be paid for services, all claims, including claims that are re-billed, must be received within 180 days of the date of service.

Charges for services provided to participants enrolled in a Managed Care Organization (MCO) or [Managed Care Community Networks \(MCCNs\)](#) must be billed to the MCO or MCCN according to the contractual agreement with the MCO or MCCN. The Department is not to be billed for services if the participant is enrolled in an MCO or MCCN.

### **S-202.2 Claim Preparation and Submittal**

Refer to [Chapter 100](#), for general policy and procedures regarding claim submittal.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix S-1 for technical guidelines to assist in preparing paper claims for processing. Note that the Department offers a claim scannability/imaging evaluation. Turnaround on a claim scannability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address:

Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East  
Second Floor - Data Preparation Unit  
Springfield, Illinois 62763-0001  
Attention: Provider/Image System Liaison

### **S-202.3 Electronic Claim Submittal**

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in [Chapter 100](#) or [Chapter 300](#).

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any

claims, including those submitted electronically. Refer to [Chapter 100](#) handbook for further details.

#### **S-202.4 Payment**

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

Refer to [Chapter 100](#) handbook for payment procedures utilized by the Department and for explanations of Remittance Advice detail.

#### **S-202.5 Fee Schedules**

The [fee schedule](#) of allowable Procedure Codes and special billing information is available on the Department's website.

## **S-203 Covered Services**

A covered service is a service for which payment can be made by the Department. Refer to [Chapter 100](#) handbook for a general list of covered services.

Listed below are reimbursable services when provided in a SBLHC setting:

- Basic medical services;
- EPSDT;
- Reproductive health;
- Mental health;
- Substance abuse;
- Dental; The Department contracts with DentaQuest of Illinois to manage the dental program.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook. For further information refer to [77 Ill. Adm. Code Section 2200.60](#).

For allowable procedure codes, refer to the [SBLHC Fee Schedule](#).

## **S-204 Non-Covered Services**

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. See [Chapter 100](#) handbook for services and supplies for which payment will not be made.

In addition, certain services provided by the center are not reimbursable by the Department to the SBLHC. The services include but are not limited to:

- The Division of Mental Health (DMH) or the Division of Alcoholism and Substance Abuse (DASA) Services. When the center determines these services are required, a referral may be made to the appropriate resource. Refer to the Handbook for Providers of Healthy Kids Services for the policy and procedures for the referral, as well as a list of referral resources.
- Any medical services not listed on the fee schedule for [SBLHC fee schedule](#) must be referred to the Managed Care Organization (MCO), a primary care provider or other appropriate source of medical care.
- Services provided off-site (not at the SBLHC site) cannot be submitted for reimbursement using the SBLHC's provider name and the provider number assigned by the Department.

## **S-205 Record Requirements**

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to [Chapter 100](#) handbook for record requirements applicable to all providers.

In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

The site must maintain an individual medical record for each participant. The record must include the essential details of the participant's health condition and of each service provided. All entries must include the date, time and signature of the practitioner rendering the service and must also be legible and in English. Transcription may be required for purposes of peer, quality of care, or utilization reviews by the Department. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted.

## **S-210 General Limitations and Considerations on Covered Medical Diagnostic and Treatment Services**

Medical services are covered in SBLHC only when provided in accordance with the [Handbook for Practitioners Rendering Medical Services](#).

It is the center's responsibility to assure that all necessary treatment and follow-up is coordinated with the patient's Care Coordination plan. The billing instructions in this handbook apply to patients enrolled in traditional fee-for-service, Accountable Care Entities (ACEs), and Care Coordination Entities (CCEs) and do not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the [HFS Care Coordination website](#).

### **S-210.1 Protocol**

The protocol is a written instrument which defines the relationship between the physician and other health care professionals at the center and identifies the medical services to be provided within the scope of each practitioner's expertise. The annual review must be written, maintained on file at the center and be available upon request by Department staff. Health care professionals are defined as a resident physician, advanced practice nurse (APN), physician assistant (PA) and registered nurse.

The Protocol on file must meet the following guidelines:

- The written document reasonably describes the kind of services to be provided and, as appropriate, criteria for referral and consultation with the physician.
- The document must specify which authorized procedures do not require a physician's presence as the procedures are being performed.
- The document must specify arrangements for communication with a physician for services that are outside of the established protocol.

Further information can be found at [68 Ill. Adm. Code Section 1300.410](#) and [68 Ill. Adm. code Section 1350](#).

Services submitted for payment to the Department that are provided by a resident physician or a registered nurse must have the supervising physician's, APN's, or PA's counter signature documented in the medical record.

## **S-210.2 Maternity Care**

To provide prenatal and postpartum care at the center, the center must comply with [77 Ill. Adm. Code Section 2200.70](#). For complete maternity care policies and billing procedures, refer to the [Handbook for Practitioners Rendering Medical Services](#).

## **S-221 Pharmacy Services**

The center may bill for injectable drugs and birth control devices only when they have been purchased by the center.

### **S-221.1 Prior Approval for Oral and Injectable Drugs**

Prior approval authorization is required for certain drugs covered by the Department's Medical Programs.

**Prior Approval Procedure:** To request prior approval, the center should complete a Request for Drug Prior Approval, [Form HFS 3082 \(pdf\)](#). The completed [HFS 3082](#) must be faxed to the Drug Prior Approval Unit at (217) 524-7264 or (217) 524-0404. The center must provide the NDC code and the State License Number of the administering practitioner at the time of the request. Whether a prior approval request is approved or denied, the participant will receive notification of the outcome of the request.

## **S-222 Medical Diagnostic and Treatment Services**

### **S-222.1 Laboratory Tests**

Only those laboratory tests and examinations which are essential for diagnosis, evaluation and treatment are covered. Batteries of “rule out” tests are not covered. The appropriate CPT or HCPCS Code is to be used when billing for laboratory tests. The Department has a maximum dollar amount payable for certain panels and chemistries. Refer to the [SBLHC fee schedule](#).

The center may charge only for those tests performed at the center using the center’s staff, equipment and supplies. When the patient presents for laboratory tests only, an office visit charge may not be made.

Centers providing laboratory services must be in compliance with the [Clinical Laboratory Improvements Amendment \(CLIA\) Act](#). The center may not charge for laboratory tests performed by any outside laboratory. Charges are not to be made when a specimen is obtained by center staff and sent out of the office.

Exception: When a specimen is obtained by the center and sent to the Illinois Department of Public Health for lead screening, the provider may bill for the drawing fee. Refer to the fee schedule for the appropriate procedure code and modifier.